PRINTED: 12/16/2010 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		445288	B. WING	910.4.0	C 12/16/2	010
	PROVIDER OR SUPPLIER		28	EET ADDRESS, CITY, STATE, ZIP 87 BAKER STREET UNTSVILLE, TN 37756	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) OMPLETION DATE
F 000 F 278 SS=D	Investigation of C/O #26903 was conduct Huntsville Manor. C/O #26119. 483.20(g) - (j) ASS ACCURACY/COOM The assessment material resident's status.  A registered nurse each assessment with participation of heat assessment is commodered assessment must be assessment in a subject to a civil modered statement in a subject to a civil modered assessment must be assessment in a subject to a civil modered assessment must be assessment in a subject to a civil modered assessment must be assessment in a subject to a civil modered assessment must be assessment in a subject to a civil modered assessment in a subject to a civil modered assessment assessment assessment.	o #26119, #26650, #26813 and cted December 7-9, 2010, at No deficiencies were cited for ESSMENT RDINATION/CERTIFIED tust accurately reflect the must conduct or coordinate with the appropriate lith professionals.  must sign and certify that the upleted.  o completes a portion of the sign and certify the accuracy of issessment.  d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a not is subject to a civil money of than \$5,000 for each	F 278	F278 483.20 (j) Resident Assess Corrective action(s) accomplish residents found to have been af deficient practice;  1. The MDS Assessment has been corrected and the resident's status.  Completion date: 12/2  Identify other residents having be affected by the same deficient what corrective action taken:  2. 100% audit of resident been completed by the and MDS Assistant to verify all residents MI accurately reflect the status.  Completion date: 12/2  Measures/systematic changes pensure the deficient practice do 3. In-service conducted to Administrator with the Assistant MDSC of Assessment of Resident's Progress/S  Completion date: 12/2  Physician orders, histopsychological and/or updates are reviewed scheduled morning mensure by MDSC to verify accurately resident's status.  Monitoring of corrective action deficient practice will not recurately resident charts per versident charts	red for those fected by the  t of Resident #17 d accurately reflects  20/10  the potential to nt practice and ts charts has e MDS Coordinator DS assessments resident's  23/10  ut in place to es not recur; by the ne MDSC, and on "Ongoing tatus".  23/10  ory & physical, behavior in regularly cettings ccuracy of MDS reflection of  to ensure the Fig. Risk Manager in NDON) will audit veek for 4 weeks to	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEC 28 f continuation sheet Page 1 of 8

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	
		445288	B. WING	NEREZ A	12/	16/2010
	PROVIDER OR SUPPLIER		287	ET ADDRESS, CITY, STATE, ZIP BAKER STREET NTSVILLE, TN 37756	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 278	Based on medical the facility failed to resident (#17) with twenty-eight reside.  The findings includ. Resident #17 was a 1, 1999 with diagnod Alzheimer's Disease Disease, Congestive Mellitus, Hypoglyce Hypertension and Consease. Review of (readmission) Body 2010, revealed the Pressure Ulcers on Pressure Ulcers on Medical record review (MDS) dated July 1 had no Pressure Ulcers on Nurse (Treatment I had two stage 4 Pressure Ulcers on Nurse (Treatment I had two stage 4 Pressure Ulcers of the conference rook the time of the body 2010 (by the forme Continued interview confirmed the wour resident's death (Signal of the conference room, we december 9, 2010 conference room, we confere	record review and interview, accurately assess one Pressure Ulcers of ints reviewed.  ed: admitted to the facility on July oses including End-Stage including End-Stage in Peripheral Vascular in the Heart Failure, Diabetes in Acute Renal Failure, Chronic Obstructive Pulmonary of a "Resident Admission in Audit" dated June 24 and 25, resident had two stage 4 in the heels and two stage 2 in the buttocks.  ew of the Minimum Data Set 3, 2010, revealed the resident	F 278	Overall findings will be the NHA immediately policy is not adhered to will be considered a vi Violations will result i action in accordance we progressive disciplinar Report of overall findis subsequent disciplinar applicable will be report facility Quality Assura Committee (consisting Medical Director, ADC Risk Manager, MDSC Consultant, Registered Wound Care Nurse) to the need for continued amendment of plan.  5. Completion date:	when  b.  cility policy colation.  n disciplinary ith the facility y policy.  ngs and y action, if rted to the nce (QA) of DON, DN, NHA, Pharmacy Dietician, review	12/31/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		445288	B. WING	- 23H			C 6/2010	
	PROVIDER OR SUPPLIER		28	7 BAKER S	ESS, CITY, STATE, ZIP ( STREET LE, TN 37756	CODE	23	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF C CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 312 SS=D	stage 2 Pressure U C/O #26650, #2690 483.25(a)(3) ADL O DEPENDENT RESI A resident who is undaily living receives maintain good nutrition and oral hygiene.  This REQUIREMENT by: Based on medical reinterview, the facility one (#5) of twenty-extra twenty-	re Ulcers to the heels and the ilcers to the buttocks.  CARE PROVIDED FOR IDENTS  nable to carry out activities of the necessary services to tion, grooming, and personal  NT is not met as evidenced  record review, observation and y failed to provide oral care for eight residents reviewed.  ed:  dmitted to the facility on March oses including Osteoarthrosis, re and Chronic Obstructive and Chronic Obstructive and Chronic Obstructive and Edical record review of the dated November 21, 2010, not required limited assistance occived greater than 50% on through a feeding tube.  Cember 7, 2010, at 1:30 p.m., not lying in bed with tube illiliters) per hour.  ed the resident's lips and domical mucus streamed from the to the lower lip.	F 278	Correcti residents deficient 1.  Identify be affect what cor 2.	the necessary services and oral hygiene.  Completion date: 12/7  Teachable moment was nurse #1 and aides #1, date of finding.  other residents having ted by the same deficie rective action taken: 100% audit of residen to carry out activities was conducted by Din Nursing, ADON, MD: Service Director, and verify all residents hancessary services to Completion date: 12/es/systematic changes pine deficient practice do	hed for those ffected by the rided s for personal and  7/10 as given to , #2, #3 on the potential to ent practice and ats whom are unable of daily living rector of S Coordinator, Social Dietary Manager to ave received the maintain oral hygiene.  10/10 ut in place to licensed nursing sing assistants  23/10 conducted lanagers to licenseds		
		resident and interview with the Nurse (LPN #1) and Certified					40	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRU	CTION	COMPL	
		445288	B. WING	1086		12/	16/2010
	ROVIDER OR SUPPLIER		28 HI	7 BAKER ST UNTSVILLE	, TN 37756		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRI CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312 F 456 SS=E	Nursing Assistants December 7, 2010, resident was in nee oral care had not be 2010. Observation on December 7, 20 and at 1:50 p.m., w care had not been p 2010. CO #26903 483.70(c)(2) ESSEI OPERATING CONI The facility must ma mechanical, electric equipment in safe of This REQUIREMEN by: Based on observatif failed to ensure resimaintained for six (a #27) of twenty-eight	(CNA #1 and #2) on at 1:43 p.m., confirmed the d of oral care and confirmed een provided on December 7, of the resident and interview 10, at 1:47 p.m., with CNA #3 ith CNA #4 confirmed oral provided on December 7,  NTIAL EQUIPMENT, SAFE DITION  aintain all essential eal, and patient care operating condition.  NT is not met as evidenced on and interview, the facility ident equipment was #22, #23, #24, #25, #26 and t residents reviewed.	F 456	deficient pr 4. E 5 c fi o C tt p F w V v a a p f f C N R C V tt tt	of corrective action to entractice will not recur; actice will not recur; and ADON (or Risk Masence of DON or ADON) residents per week of who arry out daily activities of cor 4 weeks to assure accurate fresident's oral care has be overall findings will be reported in the NHA immediately when the total in the colicy is not adhered to.  Failure to adhere to facility points will be considered a violation will result in disception in accordance with the regressive disciplinary police to the considered action of overall findings are ubsequent disciplinary actions action in accordance with the regressive disciplinary actions action of overall findings are ubsequent disciplinary actions action of overall findings are ubsequent disciplinary actions action of overall findings are ubsequent disciplinary actions action of the consisting of Dougland Director, ADON, Natisk Manager, MDSC, Phar Consultant, Registered Dieti Vound Care Nurse) to review the need for continued intervented intervented in the consultant of plan.	Manager in ) will assess m cannot daily living the reflection een met.  orted to  policy n. iplinary e facility icy.  ad on, if o the QA) ON, HA, macy ician, w	
	November 12, 2010 Chronic Back Pain, Hypertension, Eden Medical record revie (MDS) dated Nover resident required lin mobility and transfe assistance with ami	admitted to the facility on 0, with diagnoses including Congestive Heart Failure, na and History of Falls. ew of the Minimum Data Set onber 19, 2010, revealed the nited assistance with bed irs and required extensive bulation.		5. C	Completion date:		12/31/10
	revealed the reside	nt was being transported in a					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SU COMPLE	TED
		445288	B. WING _		107 907,419,602	C <b>6/2010</b>
	PROVIDER OR SUPPLIER		28	EET ADDRESS, CITY, STATE, ZIP CODE 37 BAKER STREET UNTSVILLE, TN 37756		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 456	wheelchair on the 1 Therapy Techniciar the vinyl material or wheelchair was torr foam protruding fro revealed the tear woobservation reveale tears or reddened a torn armrest.  Observation and infat 11:35 a.m., on th Therapy Techniciar the wheelchair was  Resident #23 was a November 9, 2007, Cerebral Palsy, Cor and Joint Contractu the MDS dated Nov resident was totally activities of daily livi (able to walk).  Observation on Decrevealed the resider Observation reveale armrests was torn voobservation reveale missing one inch of frame exposed.  Observation and intat 1:40 p.m., with Li #3 confirmed the wh repair.  Resident #24 was a	00 hall by the Physical (#1). Observation revealed to the right arm rest of the and had jagged edges with m the armrest. Observation as four inches in length. ed the resident had no skin areas near the location of the derview on December 8, 2010, e 100 hall, with the Physical to (#1) confirmed the armrest of in need of repair.  Indicate to the facility on with diagnoses including to the diagnoses	F 456	F456 483.70 (c)(2)Essential Equipment Operating Condition  Corrective action(s) accomplished for cresidents found to have been affected by deficient practice;  1. The equipment for Resident ## #24, #25, #26, and #27 was as by the Maintenance Director to equipment is in safe working of the Maintenance Supervise the Maintenance Supervise the Maintenance Assistant on rounds, weekly audits, and 72 follow up in conjunction with maintenance.  Completion date: 12/10/10, 12  Identify other residents having the pote be affected by the same deficient practice what corrective action taken:  2. 100% audit of residents equipment and the Maintenance Assistant all equipment is in safe operation.  Completion date: 12/17/10  Measures/systematic changes put in placensure the deficient practice does not read in supervisor and Maintenance Assistant all equipment is in safe operation.  Completion date: 12/17/10  Measures/systematic changes put in placensure the deficient practice does not read in supervisor and Maintenance Assistant all supervisor and Maintenance Assistant and the Maintenance Assistant and the Maintenance Assistant all supervisor and Maintenance Assistant all supervisor and Maintenance Assistant and the Maintenance Assistant and the Maintenance Assistant and the Maintenance Assistant all supervisor and Maintenance Assistant and the Mainte	those by the  22, #23 ssessed to assure order.  inistrator sor and daily hour preventive  2/21/10 ential to ice and ment the Supervisor to assure ing condition.  ce to ceur; nance ssistant on Program and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HRD111

Facility ID: TN7601

If continuation sheet Page 5 of 8

DEC 28 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445288	B. WING _		1.00	C 6/2010
NAME OF F	PROVIDER OR SUPPLIER	443200	10000000	REET ADDRESS, CITY, STATE, ZIP CODE		16/2010
HUNTSV	ILLE MANOR		5	87 BAKER STREET HUNTSVILLE, TN 37756		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 456	Diabetes Mellitus, Hosteoporosis. Mediated October 15, 2 was totally depended aily living and was Observation on Decrevealed the reside revealed the left arrohair was torn ½ in Observation revealed with padding exposive resident had no skin Observation and intat 1:16 p.m., with Lower was in need of repart Resident #25 was a January 18, 2005, Renal Failure, Alcolandary 18, 2010, revealed the reside Observation on Decrevealed the reside Observation revealed the reside Observation revealed armrest was torn; the and the metal frame revealed duct tape armrest to within ½ Observation and intat 1:25 p.m., with Lowelchair was in residence.	Alypertension, Anxiety and lical record review of the MDS 2010, revealed the resident ent on staff for all activities of not ambulatory.  Deember 8, 2010, at 1:16 p.m., and in a geri chair. Observation on of the padding on the geri ch with padding exposed. The enters to the footrest ed. Observation revealed the enters to the arms or legs.  Deember 8, 2010, at 1:16 p.m., and the enters to the footrest ed. Observation revealed the enters to the arms or legs.  Deember 8, 2010, at 1:25 p.m., and the entersion of the MDS dated October the resident required extensive extivities of daily living.  Deember 8, 2010, at 1:25 p.m., and sitting in a wheelchair. The entersion of the end of the armrest.  Deember 8, 2010, at 1:25 p.m., and the vinyl covering on the end of the armrest.  Deember 8, 2010, at 1:25 p.m., and the vinyl covering on the end of the armrest.  Deember 8, 2010, at 1:25 p.m., and the vinyl covering on the end of the armrest.  Deember 8, 2010, at 1:25 p.m., and the vinyl covering on the end of the armrest.  Deember 8, 2010, at 1:25 p.m., and the vinyl covering on the end of the armrest.	F 456	Guardian Rounds are conducted daily by department managers assure that all equipment is in condition.  Monitoring of corrective action to ensure deficient practice will not recur;  4. Administrator and Risk Manage will assess 5 pieces of patient of per week for 4 weeks to assure operating condition.  Overall findings will be reported the NHA immediately when policy is not adhered to.  Failure to adhere to facility policy will be considered a violation. Violations will result in discipl action in accordance with the failure progressive disciplinary policy.  Report of overall findings and subsequent disciplinary action, applicable will be reported to the facility Quality Assurance (QA) Committee (consisting of DON) Medical Director, ADON, NHA Risk Manager, MDSC, Pharmac Consultant, Registered Dietician Wound Care Nurse) to review the need for continued intervent amendment of plan.  5. Completion date:	to safe operating safe operating re the ser will sare equipment in safe sed to see set t	12/31/10

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		445288	B. WIN	G_		- 1	6/2010
	ROVIDER OR SUPPLIER			28	EET ADDRESS, CITY, STATE, ZIP COE 37 BAKER STREET UNTSVILLE, TN 37756	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 456	November 16, 2006 Subarachnoid Hem Abuse and History review of the MDS revealed the reside with activities of dai Observation on Dec revealed the reside Observation revealed armrests was fraye exposed. Observation	orrhage (Stroke), Alcohol of Falls. Medical record dated October 19, 2010, nt required limited assistance ily living.  cember 8, 2010, at 1:20 p.m., nt sitting in a wheelchair. ed the vinyl padding on both d with the foam padding tion revealed the resident had mage in the area of exposure	F 4	9.56			
	Observation and intat 1:20 p.m., with Li wheelchair was in not resident #27 was a September 18, 200 Dysphagia, Insomn Diabetes and Peptio of the MDS dated Coresident required exactivities of daily livic Observation on Decrevealed the resider revealed the right a resident's room was exposed, and the cofrayed. Observation	terview on December 8, 2010, PN #3 confirmed the need of repair.  Independent of the facility on 2, with diagnoses including ia, Depression, Hypertension, or Ulcer. Medical record review october 22, 2010, revealed the stensive assistance with ing and did not ambulate.  Independent of the wheelchair in the storn with the foam padding overing of the left armrest was in revealed the resident had no sea of the arms, which would					
	Observation and int at 1:15 p.m., with LI wheelchair was in n	erview on December 8, 2010, PN #3 confirmed the eed of repair.					